No. 93-1251

FILED

JUN 17 1994

THE CLERK

In The

Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, Secretary of Health and Human Services,
Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF AMICI CURIAE OF HOSPITALS PARTICIPATING IN *ST. JOHN HOSPITAL V. SHALALA* AND *LOSS ON EXTINGUISHMENT OF DEBT GROUP APPEAL* IN SUPPORT OF RESPONDENT

WILLIAM G. CHRISTOPHER
(Counsel of Record)
CHRIS ROSSMAN
KENNETH R. MARCUS
Honigman Miller Schwartz and Cohn
2290 First National Building
Detroit, Michigan 48226
(313) 256-7800
Attorneys for Amici Curiae Hospitals Participating in *St. John Hospital v. Shalala* and *Loss on Extinguishment of Debt Group Appeal*

Petition for Writ of Certiorari Filed February 1, 1994
Petition for Writ of Certiorari Granted April 4, 1994

QUESTIONS PRESENTED

The Secretary of Health and Human Services (hereinafter "Petitioner" or the "Secretary") has presented the following questions for review:

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issue without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

Respondent Guernsey Memorial Hospital ("Hospital" or "Respondent") in Brief for the Respondent modifies Petitioner's characterization of the questions presented as follows:

1. Whether general Medicare reimbursement regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite a contrary administrative rule issued by the Secretary of Health and Human Services to govern reimbursement of advance refunding losses.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in delaying full reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

No. 93-1251

In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, Secretary of Health and Human Services,
Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF AMICI CURIAE OF HOSPITALS PARTICIPATING IN *ST. JOHN HOSPITAL V. SHALALA* AND *LOSS ON EXTINGUISHMENT OF DEBT GROUP APPEAL* IN SUPPORT OF RESPONDENT

INTEREST OF AMICI CURIAE

Amici curiae consist of the twenty-eight hospitals in the Medicare group appeal pending before the United States Court of Appeals for the Sixth Circuit in *St. John Hospital* v. *Shalala*, Case No. 93-2334, and fourteen hospitals pending in the Medicare group appeal pending before the Provider Reimbursement Review Board ("PRRB") in *Loss on Extinguishment of Debt Group Appeal*, PRRB Case No. 91-0500G. These hospitals collectively are referred to in this brief amici curiae as the "Group Appeal Hospitals."

The Court's decision in the instant case will be dispositive of the appeals in which The Group Appeal Hospitals are engaged.[1] The Group Appeal Hospitals, which comprise the overwhelming majority of hospitals appealing the issue presented by the instant case, submit this brief amici curiae on behalf of Hospital.[2]

From a Medicare payment perspective, it is primarily the time value of money that is at stake in the instant case and that is at stake for the Group Appeal Hospitals. The true, broad based significance of the Court's decision in this case is whether the Secretary is required to follow the Secretary's own regulations in determining Medicare payment.

The Secretary specifically has referenced *St. John Hospital* regarding the purported financial significance of the instant case, stating as follows: "The significant amount of money at issue in *St. John* will be irretrievably lost if review is deferred to await the development of a more specific conflict." *Petition for a Writ of Certiorari* at 14, n. 9.[3]

Although the Secretary claims that money "will be irretrievably lost," at issue is the proper *timing* of payment, not whether Hospital or the Group Appeal Hospitals are *entitled* to payment. Indeed, the Secretary ultimately concedes that

[1] The Group Appeal Hospitals in *St. John Hospital* also filed a brief amici curiae before the Sixth Circuit on behalf of Hospital. This brief amici curiae will not repeat the detailed statement of the case, statement of facts and description of the applicable Medicare reimbursement and accounting background that is set forth in the Brief for Respondent filed concurrently with this brief amici curiae.

[2] Hospital and the Secretary have consented in writing to the submission of this brief amici curiae.

[3] This statement was made in the context of the Secretary's forecast of a conflict between the Fifth and Sixth Circuits, which proved to be inaccurate. Since the Court granted the Petition for a Writ of Certiorari absent a conflict between the Fifth and Sixth Circuits, presumably the Petition for a Writ of Certiorari was granted on this alternative basis. Thus, it seems appropriate that the amount in controversy be put in perspective for the Court.

"[i]n most cases, the amount of the allowable refunding loss is undisputed, and the only issue is whether the loss should be allowed in the year of the refunding transaction or amortized over some longer period." *Petition for a Writ of Certiorari* at 25. Thus, the Medicare program has incurred a cost for which the Medicare program is obligated to pay the Group Appeal Hospitals without regard to the outcome of this litigation. Moreover, because the advance refunding transactions of the Group Appeal Hospitals occurred in the mid to late 1980's, as a result of the passage of time most of the amortized payments under PRM § 233 for which the Medicare program is liable already have been paid.[4] The average percentage difference in Medicare payment for the Group Appeal Hospitals is approximately 7% when payment is made under GAAP, as compared to payment as required by PRM § 233.[5] While there is some slight increase in payment under GAAP as opposed to under PRM § 233, the Group Appeal

[4] The Group Appeal Hospitals have been appealing this issue for upwards of five years. The Group Appeal Hospitals are entitled to payment of statutory interest under 42 U.S.C. § 1395oo(f)(2) should they prevail. The Secretary appealed *St. John Hospital* to the Sixth Circuit and moved to stay while the Secretary was evaluating whether to file a petition for certiorari in the instant case. In that motion, which initially was denied but subsequently was granted when the petition for certiorari was filed, the Secretary expressed no concern over the amount of interest accruing while it sought to delay the ultimate resolution of *St. John Hospital*. On the contrary, the Secretary's brief in support of its motion to stay *St. John Hospital* sought to justify delay of *St. John Hospital* in part on the fact that a statutory interest award would be included in the event the hospitals prevailed. Thus, the Secretary should not now have the right to inflate the amount in controversy by referring to statutory interest. Moreover, the Group Appeal Hospitals respectfully submit that they need not offer an apology that in the event they prevail they are entitled under law to an award of interest.

[5] This slight increase is explained by the fact that the Secretary imposed reductions in Medicare capital payment subsequent to the years in which *St. John Hospital* underwent advance refunding transactions. By receiving payment under GAAP, *St. John Hospital* received the full amount of payment in the year and at the then applicable rate at which they were entitled to receive payment.

refunding."[23] Indeed, the Secretary acknowledges this crucial

[23] The record established before the Provider Reimbursement Review Board below is replete with uncontradicted evidence that Hospital was discharged of the old debt. This fact is evidenced in the Termination of Lease and Supplemental Lease, Release and Discharge of Indenture of Mortgage and Supplemental Indenture of Mortgage and Release of Guaranty, a copy of which is set forth in the *Joint Appendix* at 50–52. The Court's particular reference is directed to the following statement:

> "NOW, THEREFORE, the Issuer, the Lessee [*i.e.*, Hospital] and the Trustee hereby agree, confirm and declare that . . . the Original Indenture and the Supplemental Indenture have been and are satisfied and, by this instrument, release, cancel and discharge the Original Indenture and the Supplemental Indenture." *Joint Appendix* at 52.

This fact also is evidenced by the uncontradicted testimony of Donald Huelskamp: "That's correct. Paragraph 3D is where the debtor is legally released from being the primary obligor under the debt, which is the situation that we have incurred in the Guernsey Memorial Hospital situation." *Joint Appendix* at 17. This fact also is evidenced by the uncontradicted testimony of Douglas E. Langenfield: "In reality in 1985 the hospital relieved itself of any obligation of the 1972 and 1982 bonds . . " *Joint Appendix* at 17.

Further confirmation of this fact was requested by the Provider Reimbursement Review Board during the hearing below. This confirmation was provided by Hospital's legal counsel in Exhibit A to *Provider's Post-Hearing Brief* dated October 10, 1989: "[W]e advise you that the 1972 Bonds and the 1982 Bonds have been deemed paid and discharged within the meaning of the Prior Indenture, and *the Hospital has been released and discharged from any further obligation to pay debt service on the 1972 Bonds and the 1982 Bonds*." *Joint Appendix* at 11 (Emphasis supplied).

Testifying on behalf of the fiscal intermediary, Diane Andrews conceded the liability for the old debt was transferred to the trustee of the escrow account into which proceeds of the new debt had been deposited:

> Q. Is it a cost incurred by the trustee?
>
> A. The trustee would be making the actual payments.
>
> Q. It was a cost incurred by the trustee in addition to making the payment, it was a cost incurred by the trust?
>
> A. Yes.

fact: "[T]he establishment and funding of the escrow account released respondent from any further obligation to the holders of these bonds." *Brief for the Petitioner* at 8.

Because Hospital was no longer obligated on, and thus incurs no further loss relating to the old debt, the Medicare Act would prohibit, as an impermissible cross-subsidization, Hospital from being reimbursed for the cost of that debt in years after the advance refunding transaction. 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R § 413.9(b).[24] The Secretary also acknowledges the critical importance of this principle: "A central concern of 'reasonable cost' reimbursement is that any costs 'allowed' under Medicare must be properly matched to services provided to the program's beneficiaries during the applicable period." *Brief for the Petitioner* at 31-32.

Thus, the Secretary's argument that amortization is "reasonable" because it matches the cost of care in the year in which the care is provided is based on the undeniably false premise that Hospital remains liable on the old debt.[25] While the Secretary does not, and indeed cannot, deny this fact, the Secretary seeks to justify amortization by making an analogy "to allowable costs that relate to more than one accounting period — such as capital costs from which ben-

[24] The prohibition on cross-subsidization requires that Medicare not bear the costs of services to individuals who are not Medicare beneficiaries, and vice versa.

[25] The Secretary goes to great lengths to demonstrate to this Court that PRM § 233 is "rational," based on the statement of the Court of Appeals below that "there is nothing irrational about [PRM § 233]." Pet. App. 8a. This statement is a *dictum* to the holding that the Medicare Act requires the Secretary to promulgate regulations for the determination of reasonable cost. In the words of the Court of Appeals: "The Secretary's problem, of course, is that she has not done so." *Id.* 9a. This Court should affirm the decision of the Court of Appeals on the identical basis. Because the Secretary's principal argument appears to be a justification of PRM § 233, amici amplify Hospital's analysis by briefing the Court regarding the inherent errors in the Secretary's contentions. As cited in n. 30, *infra*, the Provider Reimbursement Review Board also found the Secretary's analysis to be flawed because it ignores that the debt has been defeased.

efits will be derived over several periods . . . ." *Brief for the Petitioner* at 32.

The Secretary's justification fails for several reasons. First, the payment at issue in this case is not for a capital cost. Second, the rationale for amortizing capital costs has nothing whatsoever to do with "benefits derived over several periods." Rather, capital costs are amortized to reflect that capital assets are consumed over several cost reporting periods rather than being fully used in one cost reporting period. *See* 42 C.F.R. §§ 413.134–413.144. In the context of this case in which Hospital no longer has liability under the old debt, applying the Secretary's logic a provider would continue to receive Medicare payment for a capital cost after the provider has disposed of, and long-since has relinquished legal title to, the capital asset.[26] Finally, the Secretary also amortizes a gain on advance refunding, when clearly the gain is not a "benefit" to the provider but rather an amount

[26] While amortization of capital costs has nothing to do with the "benefit" concept advanced by the Secretary, a more fitting analogy is the disposal of a capital asset. As with an advance refunding transaction, the disposal of a capital asset can result in a gain or loss. In essence, the Medicare program recomputes the useful life of the asset to reflect the early retirement of the asset. This recomputation of the useful life of the asset, depending upon the specific facts, could result either in a payment to the provider to reflect the provider's loss or an adjustment to reflect recapture of depreciation. Consistent with GAAP, these adjustments *occur in their entirety in the year in which the capital asset is disposed*. See 42 C.F.R. § 413.134 (f). In the case of Medicare payment for loss resulting from disposal, the Secretary generally does not amortize the payment over the remaining life of the disposed asset to reflect the "benefit" to the provider over that period. Similarly, where there is a recapture, which would be analogous to gain on advance refunding, the Secretary does not choose to amortize this detriment to the provider. Where there is an exception to the timing of recognition of gain or loss, it is done so by regulation. For example, an exception to the GAAP approach is made regarding the demolition or abandonment of assets resulting in losses in excess of $5,000 and which are not 80 percent depreciated. In that instance, the loss is amortized over the remaining useful life of the demolished or abandoned asset. *Id.* § 413.134(f)(5)(iv). Of course, however, this non-GAAP approach is authorized *by regulation*.

the provider is required to pay to the Medicare program. *Henry County Memorial Hospital* v. *Shalala*, No. IP 92-1044-C (S.D. Ind. Feb. 23, 1994) Medicare and Medicaid Guide (CCH) ¶ 42,129.

Understood in light of the uncontested facts established before the Provider Reimbursement Review Board below, the application of GAAP, not the application of PRM § 233, accurately reflects the cost of patient care. The decision in *Charlotte Memorial Hospital and Medical Center* v. *Bowen*, 860 F.2d 595 (4th Cir. 1988) is particularly instructive regarding the proper analysis of the instant case.[27] As in the instant case, the court was faced with the question of whether GAAP should be applied in the absence of a Medicare regulation to the contrary. The court refrained from reaching the issue of the Secretary's authority to depart from GAAP without regulatory basis: "Even if the Secretary, in the absence of an enabling regulation, is authorized to prescribe a regulatory interpretation [*i.e.*, in the PRM] that conflicts with GAAP, a proposition we do not decide today, the Secretary would be at the very limit of his authority in so doing." 860 F.2d at 600. Instead, the court's analysis was based upon the theory that greater scrutiny is required: "The focus of this scrutiny is whether, with respect to the type of medical cost at issue, the departure from GAAP is supported by a showing that GAAP 'do not accurately reflect the cost of patient care, as opposed to the cost of running a business.'" *Id.* [citing *Villa View*.][28]

As in the instant case, in *Charlotte Memorial* the issue was the proper timing of payment of a Medicare cost, the allow-

[27] *Charlotte Memorial* was cited by the Court of Appeals below, although its holding that the Medicare regulations require the application of GAAP did not require it to engage in the analysis set forth in that decision. Pet. App. 10a, n.2.

[28] See n. 14, *supra* and accompanying text.

ability of which was not in dispute.[29] The court found that "GAAP provide the guiding light for determining when, under 42 C.F.R. § 413.24, a hospital incurs a reimbursable debt . . . ." *Id.* at 598. The court reasoned that "the GAAP approach . . . captures the tenor of the applicable regulation [*i.e.*, 42 C.F.R. § 413.24] . . . ." *Id.* at 599. The court explained that "[t]he core of the GAAP approach . . . is that, during each cost reporting period, cost reimbursements should rationally coincide with the real debt [incurred]." *Id.* at 601.

Accordingly, the court found that regardless of when the doctors received deferred compensation, the hospital incurred liability when it set aside the money to fund the deferred compensation. *Charlotte Memorial* teaches, therefore, that for purposes of determining when a cost is *incurred* under 42 C.F.R. § 413.24, reliance on GAAP is appropriate.[30] In the instant case, upon extinguishment of the old debt, Hospital has been legally discharged from the debt, no longer has reimbursable costs related to the old debt and, therefore, cannot subsequently be reimbursed for costs which legally have been transferred.

Application of GAAP, therefore, recognizes the crucial fact that Hospital is discharged from liability under the old

[29] The provider claimed reimbursement for funds that it set aside as deferred compensation for executives. The intermediary disallowed reimbursement for the funds set aside because they were not deposited in a plan which complied with the requirements of the PRM. Under the applicable GAAP, however, the set aside funds constituted a recognizable deferred compensation expense.

[30] The Provider Reimbursement Review Board below reached the very conclusion that GAAP properly matched costs in the year in which services were provided:

> The loss was related to patient care in 1985, the year of the defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. . . . [T]he entire loss or defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Pet. App. 71a.

debt. The Secretary's policy in PRM § 233, however, ignores this reality, and thus violates the statutory prohibition on cross-subsidization.

CONCLUSION

The Judgment of the United States Court of Appeals for the Sixth Circuit should be affirmed.

Respectfully submitted,

WILLIAM G. CHRISTOPHER
(Counsel of Record)
CHRIS ROSSMAN
KENNETH R. MARCUS
Honigman Miller Schwartz and Cohn
2290 First National Building
Detroit, Michigan 48226
(313) 256-7800
Attorneys for Amici Curiae
Hospitals Participating in *St. John Hospital v. Shalala* and *Loss on Extinguishment of Debt Group Appeal*

Hospitals achieved a huge savings to the Medicare program in the approximate aggregate amount of $274,000,000 as a result of the advance refunding of debt.

The Secretary states that "[t]he issue is of continuing importance despite the ongoing transition to PPS reimbursement of capital-related costs." *Petition for a Writ of Certiorari* at 25, n.14. If the Group Appeal Hospitals are illustrative of hospitals appealing this issue, this statement is erroneous. In fact, only one of the Group Appeal Hospitals receives increased particular benefit under the Medicare capital prospective payment system methodology in the event their appeal is successful.[6] All of the other Group Appeal Hospitals will receive a decreased Medicare payment under the capital prospective payment in the event their appeal is successful.

The continuing importance of this issue, therefore, is whether the Secretary is required to comply with the Medicare reg-

[6] Medicare payment of capital-related costs for inpatient hospital services for cost reporting periods beginning or after October 1, 1991 is based on a prospective payment system methodology. 42 C.F.R. § 412.1–412.352. Under this methodology, a hospital-specific rate is computed based upon a hospital's capital-related costs during its base year, i.e., the cost reporting period ending on or before December 31, 1990. *Id.* 412.302(b). The hospital-specific rate is compared to a national average referred to as the "federal rate" and described in *Id.* 412.308. If the hospital-specific rate is less than the federal rate, the hospital receives a blended payment consisting of a hospital-specific rate component and the federal rate component over a ten-year transition period, with the hospital-specific rate component decreasing, and the federal rate component increasing, each year. *Id.* 412.340. This methodology is referred to as the "fully prospective" methodology. The Secretary's analysis contemplates this methodology. Thus, the Secretary's analysis assumes that all of the Group Appeal Hospitals underwent an advance refunding transaction during the base year, and that they all are paid under the fully prospective methodology. In fact, however, all but eight of the Group Appeal Hospitals have a hospital-specific rate higher than the federal rate, and all but one of those eight underwent an advance refunding *prior* to the base year. The remainder of the Group Appeal Hospitals are paid under a different methodology, referred to as the "hold harmless" methodology. *Id.* 412.344. Under the hold harmless methodology, only one of the Group Appeal Hospitals gains any payment advantage under this new capital-related cost payment methodology.

ulations the Secretary has promulgated as required by the Medicare Act. The United States Court of Appeals for the Sixth Circuit decided below that the Secretary is required to do so. Hospital demonstrates that no conflict exists among the federal courts, which unanimously support Hospital's position. The Group Appeal Hospitals seek to brief this Court that the decision of the Court of Appeals below also is consistent with well-established precedent, particularly with the line of cases decided by the United States Court of Appeals for the Ninth Circuit.

The Group Appeal Hospitals also seek to demonstrate for this Court that application of GAAP to determine the timing of Medicare payment for loss resulting from early extinguishment of debt through an advance refunding transaction is consistent with fundamental Medicare payment principles.

SUMMARY OF ARGUMENT

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually *incurred* . . . [which] shall be determined in accordance with regulations . . . ." 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied). The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries.

In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court of Appeals below properly held that these regulations require, in the absence of a specific regulation to the contrary, the application of generally accepted accounting principles ("GAAP") in determining payment to Hospital for losses incurred in the early extinguishment of debt through an advance refunding transaction. The Court of Appeals correctly analyzed that the Secretary's payment policy, as set forth in Provider Reimbursement Man-

ual ("PRM") § 233, is not a regulation, and that therefore payment must be governed by the applicable regulations.

Hospital briefs this Court that the decision of the Court of Appeals below is consistent with the unanimous decisions rendered by the federal courts, which include decisions of the United States Court of Appeals for the Fifth Circuit and six district courts. This brief amici curiae demonstrates for the Court that the decision of the Court of Appeals below also is fully in accord with judicial precedent, including in particular a line of decisions issued by the United States Court of Appeals for the Ninth Circuit, the leading example of which is *Villa View Community Hospital* v. *Heckler*, 720 F.2d 1086 (9th Cir. 1983). The Secretary erroneously argued below, and argues before this Court, that *Villa View* and its progeny are mistaken, and that these decisions display what the Secretary terms "intra-circuit conflict." Careful review of this line of cases reveals that the Ninth Circuit and district courts situated in the Ninth Circuit properly and consistently have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.

In addition to the Ninth Circuit line of cases, virtually every reported case in which either a hospital or the Secretary urges the application of GAAP turns on whether a Medicare regulation, rather than a provision in the Medicare Provider Reimbursement Manual, governs payment contrary to GAAP. Thus, the decision of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, and accordingly should be affirmed by this Court.

Although the holding of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, the Secretary goes to great lengths to convince this Court that PRM § 233 is "rational." This brief amici curiae demonstrates that while the application of GAAP reflects the crucial fact that Hospital has been discharged from the old or "refunded" debt, the Secretary's payment policy as set forth in PRM § 233 ignores this reality. The Medicare Act and the Medicare regulations prohibit the cross-subsidization

of Medicare beneficiaries by persons who are not Medicare beneficiaries, and vice verse. Because PRM § 233 ignores the reality that Hospital has been discharged from the refunded debt, the Secretary's payment policy results in a mismatch of costs and years in which Hospital provides services, and thereby works a statutorily prohibited cross-subsidization. Under the analysis established in *Charlotte Memorial Hospital and Medical Center* v. *Bowen*, 860 F.2d 595 (4th Cir. 1988), the application of GAAP in the instant case accurately reflects the cost of patient care.

ARGUMENT

I. THE WEIGHT OF JUDICIAL AUTHORITY HOLDS THAT THE SECRETARY'S REGULATIONS MANDATE THE APPLICATION OF GAAP IN THE INSTANT CASE

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually *incurred* . . . [which] shall be determined in accordance with regulations . . . ." 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied).[7] The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries. In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court's interpretation of these regulations is dispositive of the issue presented by the instant case.

---

[7] Hospital does not contend, and to rule in favor of Hospital this Court need not hold, that the Medicare Act itself requires the application of GAAP. The use of the very term "incurred" in the Medicare Act, however, cannot be ignored. At a minimum, use of this term strongly suggests that reliance on accounting principles is necessary for the determination of costs.

The Court of Appeals below concluded that the regulation set forth in 42 C.F.R. § 413.20 contains

> what appears to be a flat statement that generally accepted accounting principles are followed . . . . Were it not for § 233 [of the Provider Reimbursement Manual], any fair minded person reading the regulations in light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Guernsey Memorial Hospital, Pet. App. 6a. *Accord*, *Mother Frances Hospital of Tyler, Texas* v. *Shalala*, 15 F.3d 423 (5th Cir. 1994).[8]

Hospital briefs this Court that in addition to the Fifth and Sixth Circuits, six district courts have determined that the Secretary's own regulations require the application of GAAP in determining payment to hospitals for losses incurred in the early extinguishment of debt through an advance refunding. The Secretary, without addressing these cases in *Brief for the Petitioner*, summarily asserts that "the [Sixth Circuit] erred in discerning any such regulatory requirement." *Brief for the Petitioner* at 35.

This interpretation of these regulations by two Courts of Appeals and six district courts fully is in accord with precedent.[9]

[8] "We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities." 15 F.3d at 426.

[9] In contesting this interpretation, the Secretary also asserts that the Secretary's "understanding of the text of the regulations is confirmed by the Secretary's longstanding interpretation and consistent administrative practice." *Brief for the Petitioner* at 28. As demonstrated by the *amici curiae* brief filed on behalf of Respondent by Amici American Hospital Association *et al.*, however, review of applicable precedent reveals that the position of the Secretary is not consistent. While this brief amici curiae shows that legal precedent follows a consistent thread, the brief amici curiae filed by American Hospital Association *et al.* shows that the Secretary's position fluctuates to achieve the outcome desired to suit specific circumstances. *See, e.g., HCA Health Services of Midwest, Inc.*, n.16, *infra*.

Notably, the decision of the Court of Appeals below is consistent with a line of decisions issued by the United States Court of Appeals for the Ninth Circuit ("Ninth Circuit") holding that the Secretary must apply GAAP in the absence of a *regulation* to the contrary (not just a Provider Reimbursement Manual ("PRM") provision), the leading example of which is *Villa View Community Hospital* v. *Heckler*, 720 F.2d 1086 (9th Cir. 1983).

The Secretary argues that *Villa View* and its progeny are mistaken because they somehow misconstrued the Ninth Circuit's earlier decision in *North Clackamas Community Hospital* v. *Harris*, 664 F.2d 701 (9th Cir. 1980). *Petition for a Writ of Certiorari* at 13-14. Finding questionable support only in a *dictum* in footnote 16 of *North Clackamas*,[10] the Secretary concludes that *North Clackamas* stands for the principle that the Secretary can depart from GAAP through the PRM without the support of a regulation. Therefore, the Secretary concludes that the Ninth Circuit's decisions display "intra-circuit conflict." *Petition for a Writ of Certiorari* at 14.

The Secretary's misplaced reliance on footnote 16 of *North Clackamas* is immediately revealed upon further review of *North Clackamas*. In that case, the plaintiff hospital purchased another hospital and a portion of the purchase price was allocated to going concern value ("GCV"). The issue was whether the hospital was entitled to Medicare reim-

[10] Footnote 16 of *North Clackamas* states in its entirety as follows:

> The Secretary normally follows generally accepted accounting practices, 42 C.F.R. § 405-406(a) (1979), but when these practices do not accurately reflect the cost of patient care, as opposed to the cost of running a business, the Secretary reserves the right to prescribe different accounting practices. *See* 41 Fed. Reg. 46,292 (1976).

bursement for the portion of the purchase price allocated to GCV. 664 F.2d at 703. The threshold issue determined by the Provider Reimbursement Review Board ("Board") below in *North Clackamas* was the proper characterization of GCV. The Board found "that GCV 'was more akin to good will than to any other asset.'" *Id.* at 705. Significantly, the Board made this determination based upon GAAP.[11] The Board disallowed Medicare reimbursement for GCV, however, because a specific Medicare regulation, *i.e.*, 42 C.F.R. § 405.429(b)(2), explicitly provided that good will was not a reasonable cost reimbursable by the Medicare program. 664 F.2d 705, n.12. Of course, in the instant case it is undisputed that loss on extinguishment of debt is recognized as a Medicare reimbursable cost. In stark contrast to the instant case in which PRM § 233 is not supported by the Medicare regulations, the Board and the district court in *North Clackamas* relied upon a provision of the PRM which mirrored the provisions of the relevant regulation. *Id.* at 705, n.13. Therefore, *North Clackamas* supports the arguments of Hospital in this case that Medicare payment principles must be defined by Medicare regulations.

In *North Clackamas* the Ninth Circuit affirmed the Board's application of GAAP to characterize GCV, and affirmed the Board's application of the Medicare Regulations to determine that GCV was not a reimbursable cost.[12] Footnote 16,

[11] "This determination was in accordance with *standard accounting practices* made applicable by 42 C.F.R. § 405.406(a)(1979)" (redesignated as 42 C.F.R. § 413.20, 51 Fed. Reg. 34,790 (1986)) (Emphasis added). 664 F.2d at 705, n. 11. Thus, and as argued by the Hospital in the instant case, *North Clackamas* implicitly recognized that the Medicare Regulation at 42 C.F.R. § 413.20 requires the application of GAAP.

[12] Confirmation that the decision in *North Clackamas* turned on the application of the Medicare regulations is set forth in the decision of the United States District Court for the Central District of California in *Hollywood Presbyterian Hospital-Olmstead Memorial* v. *Bowen* (No. CV 87-2595, Sept. 2, 1988, Medicare and Medicaid (CCH) Paragraph 37,479). There, as in the instant case, the Secretary relied on a PRM provision that was unsupported by the Medicare regulations to deny reimbursement for

when read in conjunction with footnote 11 of that case as well as in the context of the holding, is authority for the principle on which this Court should decide the instant case, *i.e.*, that the Secretary is required to follow the Medicare regulations, and that the Medicare regulations mandate the application of GAAP.

The portion of *North Clackamas* footnote 16 stating that "the Secretary reserves the right to prescribe different accounting practices" is a mere *dictum*. It is erroneous for the Secretary to conclude based on this mere dictum that the Secretary need not follow the Secretary's own regulations. On the contrary, the law is clear that the Secretary has the right to prescribe different accounting practices only in the Medicare regulations. The Secretary misinterprets this *dictum* as authority for departing from GAAP in the PRM when there is *no* support for such a departure in a regulation. Certainly the dictum does not state that the Secretary can do so. Rather, the Secretary relies heavily on the reference in footnote 16 to the following Federal Register statement:

> [GAAP] are applicable to Medicare cost determinations only when a cost situation is not covered by 42 C.F.R. Part 405 or a [PRM]. It is only in the absence of health insurance policy that GAAP should be followed.

Brief for the Petitioner at 30, n.17.

This statement appeared, however, not in the text of a regulation, but in the *preamble* to the October 20, 1976

an employer's Federal Insurance Contributions Act ("FICA") contribution to accrued but unused vacation time. As is evident by the following statement, that court clearly recognized the distinction between the case before it, in which no regulation supported the PRM, and the *North Clackamas* case, in which the decision was governed by the regulations:

> The Secretary points to no specific principle embodied in the statute or regulations that would be contravened by the accrual of FICA taxes according to generally accepted accounting principles. Cf. *North Clackamas* (citation omitted) (amortization of goodwill held not reimbursable because attainment of profits is *unrelated to the delivery of needed health services*)

CCH, p. 18,504 (Emphasis added).

promulgation of an amendment to the Medicare regulations entitled "Limitations on Recognition for Equity Capital Purposes of Amounts Paid in Excess of Fair Market Value for Tangible Assets Acquired Prior to August 1970."[13] The Secretary's very action of amending the Medicare regulations, rather than seeking to depart from the Medicare regulations through the PRM, belies the point which the Secretary and the District Court seek to make in relying on this preamble language. At most, this language evidences the Secretary's prior naked assertion that the Secretary need not adhere to the Secretary's own regulations.

Thus, the Secretary overlooks the issue, facts and holding in *North Clackamas* and relies on a misinterpretation of a *dictum* in footnote 16 to conclude that subsequent Ninth Circuit cases issued over the succeeding decade were decided in error. On the contrary, the Ninth Circuit and district courts situated in the Ninth Circuit properly have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.[14]

---

[13] It is obvious that a preamble is not a regulation and does not have the force and effect of a regulation. Upon review of the entire preamble, it is apparent that the Secretary's actions belied the statement relied upon heavily by the Secretary that GAAP is "applicable to Medicare cost determinations only when a cost situation is not covered by [the Medicare regulations] or the Provider Reimbursement Manual." Having made this statement, the Secretary immediately contradicts it: "Because such program policy [in the form of regulations] is now being promulgated on this issue, generally accepted accounting principles are not applicable." 41 Fed. Reg. at 46,292. Moreover, while this statement was part of the Secretary's response to several commenters who argued that the Secretary's regulation regarding goodwill departed from GAAP, the Secretary responded "that the amendment is not contrary to 'generally accepted accounting principles.'" *Id.* Thus, this language is ambiguous and, in any event, does not have the force and effect of a regulation.

[14] For example, in the leading case of *Villa View Community Hospital, Inc.* v. *Heckler*, 720 F.2d 1086 (9th Cir. 1983) the Ninth Circuit was faced with this issue and clearly explained the statement in footnote 16 in *North Clackamas* that "the Secretary reserves the right to prescribe different accounting practices" as follows:

The Secretary erroneously asserts *Villa View* "mis-cited" *North Clackamas* because footnote 16 of *North Clackamas* did not specify that the Secretary's right to prescribe different accounting practices must be exercised by regulation. *Petition for a Writ of Certiorari* at 13-14. The Secretary overlooks that long before deciding *North Clackamas* or *Villa View*, the Ninth Circuit consistently has recognized that the Secretary must follow the Medicare regulations.[15] In fact, the doctrine articulated in *Villa View* has been applied consistently by the Ninth Circuit in every subsequent case in which the Secretary sought to depart from GAAP other than by regulation.[16] Additionally, the Ninth Circuit consistently

---

> Thus, where the Secretary has not prescribed different accounting practices *by regulation*, the Secretary must apply generally accepted accounting principles.
>
> 720 F.2d at 1093, n.18 (Emphasis added).

[15] For example, in March of 1980, nine months *prior* to issuing the decision in *North Clackamas*, the Ninth Circuit stated in a Medicare case: "It is by now axiomatic that agencies must comply with their own regulations while they remain in effect [citations omitted]." *Memorial, Inc.* v. *Harris*, 655 F.2d 905, 910, n.14 (9th Cir. 1980). Thus, *Villa View's* explanation that the Secretary could depart from GAAP only through the regulations was merely stating a matter which had become axiomatic and which clearly did not originate with the *North Clackamas* decision. Although the District Court below accepted the Secretary's argument that *Villa View* misconstrued *North Clackamas*, it is respectfully submitted that the District Court's analysis is inconsistent with the foregoing review of these two decisions. Indeed, the Court of Appeals below itself agrees with the Ninth Circuit that "[a]n agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through changes in interpretation unsupported by the language of the regulation." *Fluor Constructors* v. *Occupational Safety and Health Review Commission*, 861 F.2d 936, 939 (6th Cir. 1988).

[16] In *Vista Hill Foundation, Inc.* v. *Heckler*, 767 F.2d 556 (9th Cir. 1985), the Secretary relied on the PRM to deny reimbursement based on educational expenses provided to patients of an acute psychiatric facility. In finding that the PRM provision was invalid in light of the Medicare Act and the Medicare regulations, the Ninth Circuit stated "in view of the regulations she [i.e., the Secretary] has chosen to adopt, the Secretary may not deny reimbursement for the educational services at issue in this

has recognized that the Medicare regulations, when specifically applicable, supersede GAAP.[17] In the instant case the Secretary does not point to any Medicare regulation that supports the application of PRM 233 or otherwise supersedes GAAP. Accordingly, GAAP is determinative.

In addition to the Ninth Circuit line of cases, the Court should take notice that virtually every reported case in which either a hospital or the Secretary urges the application of

---

case." 767 F.2d at 566. Further, the Ninth Circuit recognized that while the Secretary might choose to "amend her regulations," in the interim "the Secretary has no choice but to follow the rules she has adopted." *Id.* That analysis is entirely applicable to the instant case.

Similarly, the Ninth Circuit made the following statement, which is equally applicable to the instant case, in *National Medical Enterprises* v. *Bowen*, 851 F.2d 291, 294 (9th Cir. 1988):

> Because the Secretary's interpretation of the Medicare Act is, by his own admission, contrary to the Medicare regulations regarding accrual accounting, because he has given no basis grounded in the Medicare Act or its regulations for this divergence, and because the accrual accounting regulation is, notwithstanding the Secretary's argument, applicable to the calculation of return on equity, we affirm the ruling of the district court.

Still another case in which the Ninth Circuit applied this principle is *HCA Health Services of Midwest, Inc.* v. *Bowen*, 869 F.2d 1179 (9th Cir. 1989), but in that case "[t]he Secretary refused reimbursement on the ground that under [GAAP] (which the Secretary is mandated to apply where an issue has not been covered by agency regulations, 42 C.F.R. § 405.405) there were no reasonable costs incurred." 869 F.2d at 1180. In holding for the Secretary, the Ninth Circuit noted that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply" GAAP. 869 F.2d at 1181.

[17] *See Vallejo General Hospital* v. *Bowen*, 851 F.2d 229, 233 (9th Cir. 1988) ("In this case the Secretary's actions are adequately supported by the language and purpose of the regulations, so we need not consider GAAP . . . "), *National Medical Enterprises, Inc.* v. *Sullivan*, 916 F.2d 542 (9th Cir. 1990) (Holding that stock maintenance costs are not "'necessary and proper' within the meaning of 42 C.F.R. § 405.451 although such costs are recognized by GAAP"); *National Medical Enterprises, Inc.* v. *Sullivan* ("[C]hallenge to the validity of a *regulation* promulgated by the Secretary") (Emphasis added).

GAAP turns on whether a Medicare regulation governs payment contrary to GAAP.[18]

The Secretary contends that the Court of Appeals misconstrued the requirement of the Medicare Act that the Secretary, in promulgating regulations under that Act "consider . . . principles generally applied by national organizations,"[19]

---

[18] For cases in which the Medicare regulations requiring the application of GAAP governed, *see, e.g., Lexington County Hospital* v. *Schweiker*, 740 F.2d 287 (4th Cir. 1984) (Secretary's reimbursement treatment upheld because consistent with GAAP); *McKeesport Hospital* v. *Heckler*, 612 F.Supp 279, 284 (W.D. Pa. 1985) ("We believe the Secretary's own regulations requiring accrual basis accounting resolves this almost metaphysical problem [of when a cost is incurred]"); *Medical Society of South Carolina* v. *Heckler* (D.S.C. February 27, 1984) (Medicare and Medicaid Guide ¶ 33,651) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought); *North Shore Medical Center* v. *Heckler* (S.D. Fla. July 11, 1985) (Medicare and Medicaid Guide (CCH) ¶ 34,991) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought).

For cases in which Medicare regulations govern over GAAP, *see Palms of Pasadena Hospital* v. *Sullivan*, 932 F.2d 982, 983 (D.C. Cir. 1991) ("Accrual accounting principles might specify something different, but the Board was concerned with statutory principles *implemented by regulations*." (Emphasis added)); *Methodist Hospital of Indiana* v. *U.S.* 626 F.2d 823, 826 (Ct. Cl. 1980) ("The Secretary and his delegate have the discretion to determine that a cost was not reasonable or not actually incurred . . . provided that they do so *consistently with existing, general regulatory and statutory requirements*." (Emphasis added)).

[19] In fact, the Medicare Act states:

> In prescribing the regulations . . . the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations.

42 U.S.C. § 1395x(v)(1)(A). This language has been interpreted as delegating to the Secretary the interpretation of reasonable costs through the promulgation of regulations:

> The precise methods to be used in determining how much a provider is to be reimbursed for its services, triggered a great deal of Congressional debate. . . . *Congress ultimately chose not to specify*

as a basis for determining "that the Act was intended to direct the Secretary to consider the financial accounting principles of 'national organizations,' and specifically GAAP." *Brief for the Petitioner* at 19-21. In so doing, the Secretary completely misconstrues the issue. There is no dispute that the Medicare Act does not require the application of GAAP in every instance.[20] The importance of the Medicare Act to this case, however, is the undisputed fact that the Act requires the Secretary to promulgate regulations governing Medicare reimbursement. 42 U.S.C. § 1395x(v)(1)(A). *See, also, Charlotte Memorial Hospital*, 860 F.2d 595 (4th Cir. 1988); *HCA Health Services of Midwest, Inc.* v. *Bowen*, 869 F.2d 1179 (9th Cir. 1989); *National Medical Enterprises* v. *Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View*, 720 F.2d 1086. The more critical, indisputable fact is that the Secretary, in promulgating such regulations, affirmatively elected to mandate the application of GAAP. 42 C.F.R. 413.20, .24.[21]

As recognized by the Court of Appeals below, had the Secretary elected to depart from GAAP with respect to reimbursement for loss on extinguishment of debt, the Secretary

---

any rigid formulae. Rather it established general statutory guidelines under section 1395x(v)(1)(A) and *authorized the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the [Act]. . . ."* (citation omitted) (emphasis added).

Springdale Convalescent Center v. *Mathews*, 545 F.2d 947, 951 (5th Cir. 1977).

[20] The Secretary apparently confused the district court below regarding this point, however, as evidenced by the following statement of the district court suggesting that the Medicare Act requires the Secretary to consider GAAP: "Given the structure of these regulations, the requirement in the statute that the Secretary 'consider,' but not necessarily follow without deviation, generally accepted accounting principles, . . . this court cannot say that the Secretary's conclusion that GAAPs need not be followed in all cases is an impermissible interpretation." Pet. App. 32a.

[21] Therefore, the Secretary contends it can disregard the Secretary's regulations requiring the application of GAAP merely because the Secretary had the option in promulgating the regulations not to require the application of GAAP.

could have and should have enacted PRM § 233.3 as a regulation. While the Secretary has enacted regulations departing from GAAP in other aspects of Medicare reimbursement, the Secretary has not done so with respect to the loss at issue in this case.[22]

The foregoing analysis demonstrates that this Court should affirm the decision of the Court of Appeals below because it is fully is in accord with the weight of judicial authority interpreting the applicable Medicare regulations.

II. APPLICATION OF GAAP ACCURATELY REFLECTS THE COST OF PATIENT CARE, WHILE PRM § 233 RESULTS IN IMPERMISSIBLE MISMATCHING OF COSTS AND THE YEARS IN WHICH SERVICES ARE PROVIDED

Hospital aptly briefs this Court that "[a]lthough Respondent has no further expenses or cost reporting related to the refunded bonds, PRM § 233 requires the hospital to report this as a reimbursable expense item in years after the advance

---

[22] *See, e.g.*, 42 C.F.R. 413.134(f) (loss on disposal of assets); 42 C.F.R. 413.17 (costs to related organizations); 42 C.F.R. 413.102 (compensation of owners); 42 C.F.R. 413.106 (physical therapy and other therapy); 42 C.F.R. 405.482 (reasonable compensation equivalent limits or physician compensation). Each of these regulations specifically authorizes a method of reimbursement that departs from GAAP. Also noteworthy is that on October 9, 1991, the Secretary issued a notice of proposed rulemaking entitled "Clarification of Medicare's Accrual Basis of Accounting Policy." 56 *Fed. Reg.* 50,834. The proposed rule, which to date has not been promulgated in final form, would codify as a regulation the following PRM provisions departing from GAAP without support of a regulation: PRM § 2305 (liquidation of short-term liability); PRM § 2146 (vacation pay); PRM § 2144.9 (all-inclusive days off); PRM §§ 2146.2C and 704.3 (FICA and other payroll taxes); PRM § 2144.8 (sick pay); PRM § 906.4 (compensation of owners); PRM § 704.5 (non-paid workers); and PRM § 2162.7 (deferred compensation). The Secretary certainly could, but has chosen to not, promulgate a regulation codifying PRM § 233.